Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CHRONIC PAIN RECOVERY CENTER
25810 OAK RIDGE DRIVE
THE WOODLANDS TX 77380

Respondent Name
AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-2453-01

MFDR Date Received
MARCH 26, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 9/12/2011, the requestor received authorization from Genex Corporation to render 80 hours of Chronic Pain Management Program to be completed between the dates of 9/7/2011 and 12/6/2011." "The HCP would like to note that all services rendered were previously authorized under the authorization letter previously described above."

On January 16, 2013, the requestor confirmed that the services remain in dispute as listed on the Table of Disputed Services.

Amount in Dispute: $4,875.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The medical bill(s) made the basis of this Medical Fee Dispute have been sent back the bill audit vendor for an additional review along with the information provided by the Requestor."

Response Submitted by: Pappas & Suchma, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 19, 2011 September 20, 2011 September 21, 2011 September 22, 2011	Chronic Pain Management Program – CPT Code 97799-CP-CA (8 hours)	$1,000.00 x 4 dates = $4,000.00	$4,000.00
September 23, 2011	Chronic Pain Management Program – CPT Code 97799-CP-CA (7.5 hours)	$875.00	$875.00
TOTAL		$4,875.00	$4,875.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, effective March 1, 2008, 33 TexReg 626, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, effective May 2, 2006, requires preauthorization for specific treatments and services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 11, 2011
   - 50-01-Services not authorized as required.
   - 50-These are non-covered services because this is not deemed a medical necessity by the payer.

   Explanation of benefits dated February 26, 2012
   - W1-Workers compensation state fee schedule adjustment.
   - BL-This bill is a reconsideration of a previously reviewed bill, allowance amount do not reflect previous payments.

Issues

1. Does a preauthorization issue exist in this dispute?
2. Does the documentation support the respondent's denial of treatment based upon medical necessity?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.600 (p)(10), states "Non-emergency health care requiring preauthorization includes: (10) chronic pain management/interdisciplinary pain rehabilitation."

   On September 12, 2011, the respondent gave preauthorization for 10 sessions (80 hours) of chronic pain management program with a start date of September 7, 2011 and end date of December 6, 2011.

   Therefore, the requestor has supported position that the disputed services were preauthorized and the insurance carrier's denial based upon reason code "50" is not supported.

2. 28 Texas Administrative Code §134.600(h) states "Except for requests submitted in accordance with subsection (g) of this section, the carrier shall approve or deny requests based solely upon the medical necessity of the health care required to treat the injury..."

   28 Texas Administrative Code §134.600(l) states "The carrier shall not withdraw a preauthorization or concurrent review approval once issued. The approval shall include:
   (1) the specific health care;
   (2) the approved number of health care treatments and specific period of time to complete the treatments; and
   (3) a notice of any unresolved dispute regarding the denial of compensability or liability or an unresolved dispute of extent of or relatedness to the compensable injury."
   Therefore, the respondent has not complied with 28 Texas Administrative Code §134.600(l) by retrospectively denying preauthorized treatment based upon medical necessity.

3. 28 Texas Administrative Code §134.204(h)(1)(A) states "(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR."

   28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

   > (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.
   >
   > (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

   The Division finds that the requestor billed CPT code 97799-CP-CA for 39.5 hours on the disputed dates of services. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(A) and (5)(A) and (B), the MAR for a CARF accredited program is $125.00 per hour x 39.5 hours = $4,937.50. The carrier paid $62.50. Therefore,

the difference between the MAR and amount paid is $4,875.00. This amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $4,875.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4,875.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		1/17/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.